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A Review of Mandatory Continuing Medical Education in Oregon

MERLE PENNINGTON, MD, *Tualatin, Oregon*

NEARLY SIX YEARS have passed since the Oregon Medical Association agreed that its members should be subject to compliance with minimum standards of performance in continuing medical education. As a result of this decision, some members have been expelled, or have resigned rather than comply with requirements for membership. Today, the association's educational requirement is considered no more than what it really is—merely one of several standards for membership in this state medical association.

In view of the predictions made by many observers when the Oregon Medical Association actually implemented the mandatory education requirement in 1969, it is worthy of note that the association still exists and is in fact a growing and vital organization. Detractors within and outside the OMA's membership prognosticated, at best, mass resignations; and at worst, wholesale refusal to comply with the requirement. Since such eventualities would have rendered the program ineffective and the organization helpless, many delegates who voted for the plan in April, 1968, did so with grave reservations.

The plan, or rather the basic idea from which it sprang, came from the Oregon Medical Association's Council on Medical Education. The council, itself only two years old, had been struggling since its birth with ways and means to improve medical education, particularly for the practicing physician. The Council on Medical Education was created in 1965 by the association's House of Delegates, which felt the state and county medical societies were playing a diminishing role in selecting, producing, and monitoring the scope and quality of continuing education for practicing physicians in Oregon.

The council's charge was to reverse this trend, and in so doing to affect conditions in the state so that education for Oregon's practicing physician was relevant to his needs, practical when applied to the problems he faced, and effective. As demonstration of the high priority attached to these tasks by the House of Delegates, the new panel was given the elevated status of a council as distinguished from a committee. The House of Delegates also raised OMA dues by $10 a year to give the Council on Medical Education adequate funds and the financial independence felt necessary to deal effectively with the problems presented to it.

The council's first two years of existence were devoted to strengthening ties with the University of Oregon Medical School, specialty societies and other purveyors of continuing education for physicians in the state. The council also grappled with a myriad of tangential issues before it finally began to move toward a more direct and active role.

In early 1968, after generating masses of reports, studies and surveys, the council decided it must supplement its detached position as a coordinator and overseer of educational activities

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Dr. Pennington is chairman of the Oregon Medical Association's Council on Medical Education, a position he has held since 1969. He is also current secretary-treasurer of the Oregon Medical Association.

Reprint requests to: M. Pennington, MD, Chairman, Council on Medical Education, Oregon Medical Association, 2164 SW Park Place, Portland, OR 97205.

for physicians with a more aggressive posture in assuring the quality and effectiveness of continuing medical education in Oregon. Council members were, however, opposed to actually producing programs, feeling that such efforts would be duplicative and extremely expensive.

Establishing Standards

The council decided the OMA could be most effective in influencing the continuing education component of quality medical care by establishing standards for participation in programs, courses, and other less formal educational activities for its own members. It was also decided that some form of quality standards should be applied to medical educational activities in the state. Thus, the decision to make participation in a certain amount of continuing education each year a requisite to association membership came about.

At its midyear meeting in April, 1968, the OMA House of Delegates adopted two recommendations of the Council on Medical Education:

1. That minimum requirements be established for continuing education of the physician members of the Association:

2. That an evaluation mechanism be established regarding the quality of continuing education programs and modalities available.

The House also directed the Council on Medical Education to implement the new policy.

During the ensuing year, the council developed a program which concentrated almost entirely on the first recommendation. At the outset it was agreed that no blanket requirements could be fairly or effectively applied to all members of the association. First, special consideration must be given to members who actually did not practice medicine. In response to this problem the council defined the practice of medicine as, " . . . diagnosis and/or treatment of patients." The council also agreed that life members (OMA members for 30 years who were 65 years of age or older) would not be required to comply by reason of their honored and somewhat honorary status in the association. Resident, intern, and other members in fulltime training would also be exempted from participation.

The council also agreed to recommend that members in ill health, temporary absence from practice, or subject to other extenuating circumstances might be, at least temporarily, exempted from participation in the program. A plan to provide tailor-made requirements for members with special problems was also developed. For example, a physician with a hearing defect might apply to the council for requirements with provisions which did not compromise his ability to fulfill those requirements.

At first the council decided that all other members should adhere to generalized requirements of performance in continuing education each year. However, after some study of this decision, it became clear that no single protocol could be applied to all physicians. The council's change of heart was largely based on results of a study of Oregon physicians' participation in continuing education in its many forms. Responses from various specialties showed wide variance in the modalities considered to be of optimum value. Surgeons, for example, generally ranked formal lectures in their field to be of greater value than any other educational activity, while internists attached less value to didactic presentations than to several others forms of educational endeavor. Respondents' records of time spent in various forms of activity tended to confirm their subjective assessments of the relative value of these activities.

Specialty Requirements

Consequently, a decision was made to develop requirements by specialty, allowing activities to be included or even weighted if they were considered to be of particular value. The council felt such requirements obviously should be developed by the specialties themselves so that such requirements might most clearly reflect the value of various educational activities as assessed by peers in each specialty. Therefore, the various state or regional specialty societies were asked to establish educational requirements unique to their discipline.

In assigning this task to the specialty groups, the council gave two basic criteria which must be incorporated in the requirements in order to be acceptable to the association: (1) Compliance with requirements must involve a certain minimum of participation in terms of time expended (at least 50 hours a year); and (2) compliance with requirements must involve what the group felt was necessary to maintain or improve on the level of knowledge needed to function satisfactorily in the specialty field.

A total of 15 specialty requirements had been developed by April of 1969. Members for whom

specialty requirements had not been established would be asked to fulfill "general requirements" set forth by the council. The general requirements also were and have been used as a model or point of departure in the development of other specialty requirements.

These requirements, a policy statement regarding who must participate and a detailed plan for administration of the program were presented to the House of Delegates in the spring of 1969 under the title "Postgraduate Education Program of the Oregon Medical Association." The selection of the term *postgraduate* rather than *continuing education* has never been clear; however, suffice it to say this somewhat inaccurate title is considerably less colorful than some of the less formal names it has subsequently collected.

The House of Delegates Action

Even though the concept had previously been approved, the Council on Medical Education was apprehensive regarding the House of Delegates' willingness to implement an admittedly controversial program. Surprisingly the policy statement, specialty requirements, and necessary bylaws amendments were unanimously adopted. The House did make a significant change, one which undoubtedly served to strengthen the entire program. After considerable debate, the House directed the council's suggested statement of policy regarding application of the program be further defined so that any physician member of the association engaged in the treatment of patients would be required to complete the educational requirement. The revised version of the policy statement read: "In general all members actively engaged in the diagnosis and treatment of patients, *to even a limited extent,* must participate [in the program]." This new provision meant that all members, even the semi-retired life member physician, would be required to participate fully in the mandatory program.

It was the House's position that if the program was to be of real effect and bearing, it should be universally and uniformly applied. Although this more strict provision has proved to be the source of a great deal of administrative difficulty and hard feelings on the part of older members, four years of experience with the program reveals that the House of Delegates' edict was a wise one.

Finally the House of Delegates directed that the program become effective January 1, 1970. During the eight months before implementation, the council engaged in a "dry run" in an effort to test the administrative portion of the continuing education requirement. Oregon Medical Association members were asked to participate voluntarily in the program based on their record of educational activities for 1969. The experiment was not mandatory, and the option to participate was extended to all members of the association. Of some 2,200 members, 734 had reported on their educational activities by early 1970. Of these, a total of 698 reported participation sufficient to fulfill their respective specialty requirements. Satisfactory completion of the voluntary requirements was noted by a certificate very similar to that of the American Medical Association for its Physician Recognition Award.

Explaining the Program

Officers and staff spent a great deal of time traveling around the state attempting to explain the mandatory as well as the voluntary program. Although these meetings were not always pleasant, they undoubtedly were of value from a public relations standpoint. Individual members were given an opportunity to verbalize their objections and their suggestions, while OMA representatives could at least try to meet these complaints at the outset.

The voluntary reporting experiment indicated several deficiencies in the reporting procedure and the general administrative plan. Association staff had an opportunity to correct these problems before implementation of the mandatory program in 1970. Further, it gave all physicians an opportunity to become aware of the requirements which they would be expected to fulfill in 1970, whether or not they decided to report voluntarily on their 1969 activities.

In preparation for the initial 1970 mandatory reporting year, the association's staff prepared detailed explanatory material as well as a "physician record-keeping card" and a copy of each physician's respective specialty requirements. These packets were mailed to all physician members who were required to participate in the program during 1970. Then, at least until December 1970, the association could do little of consequence to encourage participation in the program, except to insert further amplification and explanation of the program in OMA and specialty newsletters and other periodicals.

Approximately a month before the end of 1970, members required to participate received another

detailed letter of explanation regarding reporting procedures, the importance of participation in the program and a relatively low-key explanation of what they could expect if they did not report activities sufficient to satisfy their requirements. Included with this explanatory letter was a reporting form customized to each participating member's specialty requirements. The form outlined in detail the provisions of each specific activity eligible for credit and where appropriate also noted the dates, titles and locations of major activities in that category. Participating members were also notified that they should report their activities for 1970 no later than February 28, 1971.

It was at this juncture that the great majority of serious objections to the program generally or to its specific provisions surfaced. By the end of January 1971, the Council on Medical Education had received some 200 letters objecting to certain requirements of the program, requesting exemption from mandatory participation because of extenuating circumstances, or simply damning the concept of mandatory education. In addition, the association staff received dozens of calls each day. Generally, however, these calls requested additional information or assistance in completing the reporting procedure properly.

The General Acceptance

Still, despite numerous predictions to the contrary, at the end of January, 1971, 41 percent of the 2,014 members who were required to comply with the program had done so. In early March a second reminder was sent to members who had not yet reported on their 1970 activities. This reminder predictably elicited a new stream of objections, questions, and requests for exemption. However, by March 24 a total of 1,386 of 1,982 members required to participate had complied satisfactorily with their respective specialty requirements. This figure represented 69.9 percent participation, a percentage of compliance approximating the number of members the program's most vehement critics had predicted the association would lose. By May 15 approximately 82 percent of those required to comply had done so.

At that point the members and the staff of the Council on Medical Education initiated an intense personal campaign to elicit responses from remaining members. This effort involved personal telephone calls or correspondence with all nonreporters. These members were reminded of the mandatory nature of the program and were asked to make any comments and suggestions, or to lodge criticisms they felt appropriate. In most cases the physicians advised their interviewer they had simply neglected to report out of forgetfulness or the press of other business. The telephone and letter-writing campaign naturally offered the council and its staff an opportunity to discuss on a personal basis the objections of individual OMA members. This time-consuming and expensive campaign was unquestionably successful, as many physicians immediately reported after being contacted. In fact all but the most severe critics could be convinced the program had value and was here to stay, for by that time the council and its staff had become quite adept at debating the merits of the mandatory program simply because they had heard all the arguments there were to hear.

By late August, 154 members had not reported in satisfaction of their respective specialty requirements. This list was reviewed by the Council on Medical Education and then transmitted to the OMA's Board of Trustees, with a recommendation that the board assume formal jurisdiction over the remaining individuals. At its September meeting the Board of Trustees reviewed the list and consequently voted to declare such members delinquent and to initiate proceedings leading to expulsion, effective December 31, 1971.

By November 5, the list of noncompliers had shrunk to 88 members. Upon review of this list the board adjourned to meet as the association's Board of Censors. It directed the secretary-treasurer to notify members that proceedings to consider their suspension from membership, effective December 31, 1971, would be held on December 12. The formal correspondence was also quite explicit as to what consequences suspension from membership would have with respect to participation in association insurance programs and other benefits of membership. In accordance with association bylaws, approximately a week before the scheduled hearings, each delinquent member was notified as to the time he would be expected to appear to present evidence in his own behalf. Members in this group were also given an opportunity to submit written comments, to waive the hearing entirely, or simply to agree to report before the end of the year.

During the ensuing week 35 more members chose to report rather than to face suspension by the Board of Censors, and the board finally considered the cases of 53 members. Of these, the board exempted four physicians from participa-

tion; accepted the reports submitted by two others; and granted continued hearings to another ten members in order that they be given additional time to take postgraduate courses which would satisfy their requirements. Thus, a total of 37 members were expelled by the board, expulsion to become effective December 31, 1971.

After the disciplined members were so notified, 28 reported before the end of the year, leaving a total of nine members who were actually suspended from membership. Since two of the physicians who had been given continuances were unable or unwilling to complete and report their requirements in the extra time allowed by the board, a total of 11 were actually expelled from membership in the association by March of 1972. Of the 11 subjected to disciplinary action, four physicians eventually completed their requirements, reported them to the association, reapplied for membership, and were subsequently accepted. The total number of permanent suspensions from membership was seven.

News Media and Public Interest

Both supportive and critical observers of the association's program had been primarily concerned with the potential loss of membership due to the mandatory nature of the requirement. They argued that the presence of compulsion in the program was inconsistent with expectations of the typical member regarding a medical association's role. The record really does not support these concerns, for a total of 20 physicians are no longer members because of the compulsory education program's implementation in 1970.

Two members resigned during 1969 after the program was formally adopted. They advised this was a means of formal protest against its adoption. During 1970 five physicians either resigned or were dropped from membership for non-payment of dues. Each cited the continuing education requirement as his reason for withholding dues. In 1971 eight physicians resigned rather than report their educational activities for 1970. Since that time two additional members who either were dropped, resigned or were suspended have reapplied for membership and are participating in this and other OMA programs. Thus, the net loss in membership because of the institution of the compulsory education requirement was 20, considerably less than one percent of the association's current membership.

Although the membership's initial reaction to and performance under the program was considerably more positive than even the most optimistic observers had expected, the eventual reaction of the public and the lay press must be considered most unusual. Although the OMA felt that its action with respect to certain of its members was significant from an internal standpoint, it was most surprised to find an intense interest on the part of the press and the general public.

Shortly after the end of 1971, when the noncomplying members were actually suspended from membership, a brief account of the action was included in the association's newsletter. Since it was felt the situation was of interest only to the profession, no public comment was made. Apparently the newsletter article was picked up by a local reporter, because the association officers and staff suddenly found headline articles in metropolitan Portland newspapers regarding the suspension of several OMA members for "failure to keep up." Before the day ended, many newspapers throughout the country carried similar accounts.

During the days following the appearance of the article in the lay press, the association received hundreds of calls and letters requesting further details, interviews, and, not unpredictably, the names of the physicians who had been expelled. Although some of the calls were from writers for medical periodicals, a significant number were from lay reporters throughout the country. The bulk of the inquiries, however, came from the general public.

The typical caller wanted to know if his doctor was "okay." The association responded that if the individual's physician was a member of the Oregon Medical Association he was not among those who had been suspended for failure to complete educational membership requirements. The association staff was instructed to advise the caller that it was perfectly legitimate for the individual concerned about the fact his physician was not a member to ask the doctor why. The staff also explained there were a variety of reasons why physicians might not belong to the association, and because of these numerous factors the questioner should not draw any conclusions regarding a physician based on his decision not to belong. Additionally, the response was to be positive with respect to association membership: If a physician was a member, he was satisfying certain educational standards of his state medical association.

Although public interest soon tapered off, it is interesting to observe that numerous members

called the association offices asking for a replacement for the OMA membership certificate which they had earlier "lost."

Adjustments in Requirements

After its trial by fire, the program underwent several changes which were designed to make fulfillment of the reporting and record-keeping requirement less burdensome to the individual physician. The major change was extension of the reporting cycle from one year to three. During the first year of experience with the program, it became quite clear that it is really unfair to apply static performance requirements to physicians each year, since most appeared to engage in heavier educational activity periodically rather than constantly or evenly. The association found many members might do very little in the way of continuing medical education during a given year, but the next year might devote a large amount of effort and resources to their professional education.

Beginning in 1971, members were asked to report their activities every year, and were only required to satisfy the requirement by the third year. Although some minor changes in specialty requirements were made because of this change, the primary provision was simply to treble the total requirement. For example, if an internist had been required to report a total of 100 credits during 1970 he would be asked to report a total of 300 credits for the period 1971-73. The OMA has just completed this second phase and is satisfied that the final deadline for this first three-year certification period will pass uneventfully. With a year to go before all members must comply, nearly 70 percent have done so.

Since the institution of the program, the Oregon Medical Association has also negotiated arrangements with the American Medical Association and the American Academy of Family Physicians so that satisfactory performance in the OMA program automatically qualifies appropriate members for the AMA Physician Recognition Award and Academy members for their three-year membership requirement. Conversely, if an Oregon physician chooses to apply independently and receives the AMA Physician Recognition certificate, he is considered to have fulfilled the OMA's education requirement for that period. The same holds true for Oregon family practitioners who maintain membership in good standing with the American Academy of Family Physicians.

Based on its experience with the program, the Council on Medical Education has become considerably more flexible with respect to granting credit or exemption from participation by individual members in special programs. For example, members who contribute a considerable amount of time to the training of emergency medical technicians are allowed generous credit for this activity, regardless of whether or not their individual specialty requirements allow credit for the instruction of paramedical personnel. Other examples include granting of two or three year exemptions for the individual practitioner who may take an abbreviated fellowship or residency in a particular field of interest. Such special dispensation was recently granted to a general practitioner-surgeon in a small industrial town in central Oregon who felt he needed more training to handle the numerous hand and foot injuries with which logging and sawmill worker patients presented him. He decided to take a one-year residency in hand surgery. For this activity, he was granted a two-year exemption from participation in the program.

Evaluation of Courses

The debate regarding the value or even the legitimacy of the mandatory continuing education program continues unabated. Since this descriptive account of the history, current condition, and future plans for this program is not intended to be in its defense, the writer will not attempt to summarize the current status of its pros and cons. It does seem appropriate, however, to point out some very real and measurable benefits which have accrued because of the existence of this program in Oregon. First, there has been a predictable and very healthy increase in interest in programs which are produced for physicians in the state. Since the educational requirements of the association are designed to allow the individual to fulfill the great majority of his requirements without straying far from home and practice, this is not surprising. However, what is surprising and encouraging is the simple fact that Oregon physicians today are demanding a great deal more from the programs which they attend. Based on continuing dialogue with individual physicians, it is the Council on Medical Education's position that Oregon doctors feel if they must meet certain educational requirements, what they do should be of direct benefit to them and to their practice.

In any instance where participants in a program

are provided with an opportunity to subjectively evaluate any given course or program, one criterion of measurement almost always appears in these evaluations—practicality. Today Oregon physicians consistently evaluate an educational opportunity on how it applies to their own practice and how it will better equip them to deal with the problems they see day to day.

Oregon physicians' preoccupation with relevance and practicality in educational programs is to be considered healthy because it demonstrably has made the traditional purveyors of continuing medical education in this state work to provide programs which are indeed relevant to the audience they intend to serve and practical to the needs of that audience.

It is fair to say that at least tangentially because of the mandatory educational program's existence, the typical Oregon physician is beginning to evaluate himself with a mind to seek educational opportunities which will strengthen his abilities as a physician in his own practice.

The Effect on the Learners and Their Association

These general impressions are supported by a preliminary Council on Medical Education staff study which indicates Oregon Medical Association members participate in considerably more continuing medical educational activities now than they did in 1968. This study also reveals in general that Oregon physicians spend more time participating in seminars and courses on limited subjects, rather than in attending meetings and other activities of a more general nature. This shift of desires and attitudes is clearly reflected in the changes which the Oregon Medical Association's annual scientific meeting has undergone. During the past three years this meeting has evolved from one which depended almost entirely on general and specialty scientific sessions to one with few general plenary sessions and a great number of short courses and roundtable discussions on subjects of limited but fairly common clinical interest. This trend in meeting planning is also being followed by most other specialty and voluntary health associations sponsoring educational programs for physicians in the state.

In summary, the major value of the program at present can be identified as a gradual realization by many Oregon practitioners that continuing medical education could much more accurately be described as continuing medical learning and application. In other words, the individual physician's educational needs must be personally assessed with some reference to his peers and their performance. When faced with performing a certain amount of educational activity, the physician takes a more introspective look at exactly what he can do to strengthen his own professional weaknesses.

In order to support and encourage this attitude, the Oregon Medical Association is attempting to initiate programs and other means of education designed to meet the needs of medical communities or, more specifically, the needs of the individual practitioner. Probably the most successful effort of the association for the individual has been the Doctor to Doctor Community Teaching Project (DDCT). The DDCT concept is simply to provide administrative assistance in getting a physician with a personally-determined need together with a physician in his or a nearby community who is particularly adept in the technique or procedure in question. The preceptee then spends a half-day or more in the instructor's office observing and assisting the preceptor with his patients. For example, a general practitioner might see several patients with an orthopedist in the specialist's own office in order to learn how to conduct an adequate examination of the back.

Other efforts by the Council on Medical Education have been intended to encourage continuing programs of local assessment of community needs. Generally such programs have been initiated through the small community hospital, utilizing chart review, PAS and MAP, and other traditional hospital committee tools to determine problems which the medical staff does not handle particularly well. The council then provides assistance in the design of whatever educational or system change is necessary to improve the community's performance.

It is expected that the positive attitudes of physicians regarding their personal continuing educational activities can be strengthened and supported by the association; and the producers of continuing medical education activities can be similarly encouraged to improve the relevance and practicality of their offerings. The development of methods to effectively evaluate these offerings and their effect on the practices of Oregon physicians is clearly a field in which this association is moving more slowly than is desirable. Since the development of a mandatory continuing education program was only one of the two charges assigned

to the Council on Medical Education by the association in 1968, the council must now turn to the creation of a truly effective plan for program accreditation, for the most relevant and practical educational activity is of no value unless it positively affects the practices of the physicians who participate in the program. Ultimately the effect of an educational program must be the improvement of patient care.

Despite considerable testimony to the contrary, the Oregon Medical Association's Council on Medical Education is unconvinced that effective, economical, and practical means of measuring the quality of medical care on an on-going basis are currently available. Of course such a system is the ultimate solution to the problem of defining and measuring competence in medical practice. Such a solution does not yet exist however.

The answer probably lies in the automated and computerized data collection systems which planners of medical peer review systems envision. This route of attacking the problem will undoubtedly be greatly assisted by the implementation of Professional Standards Review Organizations throughout the country. Regardless of the fears held by many physicians with respect to comprehensive peer review systems, particularly those mandated by a government apparently more concerned with cost control than with quality, few can effectively debate that such systems, used properly, will not measure physicians' competence where it really counts—in their offices and at the bedsides of their patients.

Until that time, however, the profession can only offer partial solutions to the problem of systematically monitoring and improving the quality of patient care. Progressive steps in this field are being taken. An excellent example is the development and refinement of the self-assessment model by many national specialty societies. A similar approach is the rapidly growing number of computer-based patient simulations, which offer the practitioner an approximation of the patient encounter where his performance can be compared with that of other physicians.

Periodic recertification by the American Board of Family Practice and the serious consideration of the same move by several other boards is another partial solution. Likewise, mounting opinion in favor of periodic relicensure can be considered a step toward an answer to the problem.

Based on its experience, the Oregon Medical Association feels its mandatory continuing education program is among the several approaches available to the profession in assessing and improving its individual and collective ability to provide optimal care. Still, this and other efforts are no more than temporary means because they do not directly measure nor do they guarantee improvement of actual performance. In short, the Oregon Medical Association does not consider its program a panacea. Rather the program is to be judged as a small but positive step toward dealing with the profession's major responsibility to its patients—assurance that care delivered is of high quality.